

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 162

11259

1. PLACE OF DEATH:

County Garett
 City or town R.D. 1 Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or direct address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garett
 City or town R.D. 1 Grantsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME

Christain A. Beachy

3. (b) Social Security Number

none

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Marry Beachy
 6. (c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) March 24- 1870
 8. AGE: Year 77 Months 9 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Rural Near Grantsville Md
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business

12. Name Aron Beachy
 13. Birthplace Springs Somerset Co-Pa
 14. Maiden name Catherine Folk
 15. Birthplace Springs - Somerset Co-Pa

16. Informant Clyde Beachy
 Address Grantsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 12-31-1947
 (month) (day) (year)
 Cemetery or crematory Springs

Location Springs Somerset Co-Pa
 18. Funeral director Edwin Winterberg
 Address Grantsville Md

19. Dec 30 1947 Ethel Broadwater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 - 1947 at 8 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1947 to Dec 28 1947
 and that I last saw him alive on Dec 22 1947
 Immediate cause of death Cerebral Myocarditis

DURATION _____
 Due to _____
 Due to _____

Other conditions _____
 (Include pregnancy within 8 months of death)
 Major findings of operations _____
 Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE M. R. D. Davis M.D.
 Address Grantsville Md Date signed Dec 29 1947
 M. D. or other _____

RECEIVED

JAN 3 1948

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11260

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett
 City or town Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Grantsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Marshall Beachy

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Eva Beachy
 6. (c) If alive, give age 68 years
 7. Birth date of deceased (mo., day, yr.) May. 17, 1872
 8. AGE: Years 75 Months 6 Days 28 It less than one day
 hrs. min.

9. Birthplace Grantsville Garrett Maryland
 (Town, county, and state)

10. Usual occupation Trucker

11. Industry or business

12. Name Abraham Beachy
 13. Birthplace Not Known
 14. Maiden name Delia Mayhew
 15. Birthplace Not Known

16. Informant James Beachy
 Address Grantsville, Md.

17. Burial Date thereof Dec. 13, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Grantsville
 Location Grantsville, Maryland

18. Funeral director Wm. Winterberg
 Address Grantsville, Maryland

19. Dec 18 47 Ethel Bovaduator
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947 at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to Dec 16 1947 and that I last saw him alive on Dec 15 1947

Immediate cause of death Cranial Neoplasms DURATION 3 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. R. Davis M.D. M. D. of other

Address Grantsville Md Date signed Dec 18 47

RECEIVED
DEC 19 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11261

166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Rebecca Jane Beeghly

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female

white

widow

6. (b) Name of husband or wife James W. Beeghly7. Birth date of deceased (mo., day, yr.) May 18th 1959 6. (c) If alive, give age years8. AGE: Years 88 Months 6 Days 12 It less than one day hrs. min.9. Birthplace McHenry Maryland
(Town, county, and state)10. Usual occupation House Wife11. Industry or business Widow of Jacob Pysell12. Name Garrett Pa.

13. Birthplace

14. Maiden name Rebecca Keller15. Birthplace La ncaster Pa.18. Informant Harry BeeghlyAddress Oakland, Md.17. Burial Date thereof Dec. 4 47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory CemeteryLocation Maple spring - Eglon, W.Va.18. Funeral director Wayne C. SpiggleAddress Davis, W.Va.19. 12/4/47 19. 47 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st 19. 47 at 11.45 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3rd 19. 47 to December 1st 19. 47
and that I last saw him alive on 19. 47Immediate cause of death Cerebral hemorrhageDURATION
3 daysDue to High blood pressure
and hardened arteries

history

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Julia A. Rowan M. D. or otherAddress Oakland, Maryland Date signed 12/4/47

Mr. Haggard.
Quinn-Stone Family Lodge.

12

RECORDED
DEC 10 1947
ST. HELENS V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11262

Reg. Dist. No. 177

1. PLACE OF DEATH:

County... Garrett
 City or town... Rural - Bitteringer
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Life time
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Garrett
 City or town... Rural - Bitteringer, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Susan Brenneman

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife xxx Simon Brenneman

7. Birth date of

deceased (mo., day, yr.)

June. 22, 1881

6. (c) If alive, give age. years

8. AGE:

Years

66

Months

6

Days

2

If less than one day

hrs.

min.

9. Birthplace (Rural) Accident-Garrett-Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

Christian Klotz

13. Birthplace

Germany

MOTHER

14. Maiden name

Mary Pope

15. Birthplace

Not known

16. Informant

Mr Lawrence Brenneman (Son)

Address

Rural - Bitteringer, Md.

17.

(Burial, cremation, or removal. Which?)

xxxx Bitteringer

Cemetery or crematory

Bitteringer, Maryland

18. Funeral director

Address

Grantsville, Md.

19.

(Date rec'd by registrar)

Dec. 28 1947J. B. Ensign Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1947 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 24 1947 to Dec 25 1947and that I last saw him alive on Dec 24 1947

Immediate cause of death

Tobacco Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

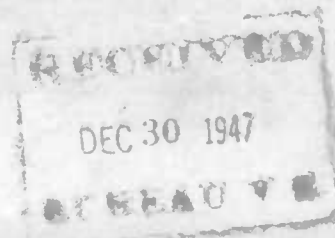
Means of injury Injured at work?

23. SIGNATURE

W. P. Dammick M. D. or other

Address

Date signed Dec 26, 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11263

Reg. Dist. No. 171

1. PLACE OF DEATH:

County Garett
 City or town Bitteringer
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garett
 City or town Rural - Bitteringer Twp.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Oliver Cromewelle Buckel

3. (b) Social Security Number

None

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>	
6. (b) Name of husband or wife <u>Ruth Buckel</u>			
6. (c) If alive, give age <u>61</u> years			
7. Birth date of deceased (mo., day, yr.) <u>December 10 - 1879</u>			
8. AGE: <u>67</u> Years	<u>II</u> Months	<u>28</u> Days	If less than one day hrs. min.

9. Birthplace Bitteringer Md
 (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

12. Name Joseph Buckel
 13. Birthplace Germany
 14. Maiden name Alice Bitteringer
 15. Birthplace Bitteringer Md

16. Informant Rex BuckelAddress Bitteringer Md

17. Burial Date thereof Dec. 7 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BitteringerLocation Bitteringer Md18. Funeral director Miss WinterbergAddress Grantsville Md

19. Dec 6 47 J. B. Emery
 (Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1947 at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947 to Dec 5 1947 and that I last saw him alive on Dec 3 1947

Immediate cause of death

Carcinoma of pancreas

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. A. Davis M.D. M. D. or otherAddress Grantsville Md Date signed Dec 5

179

10

RECEIVED

DEC 9 1947

BUREAU

page 3 of 22 2nd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11264 166

1. PLACE OF DEATH:

County Garrett
 City or town Oakland, Maryland, Route 2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Oakland, Maryland, Route 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

William Henry Chambers.

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced.
 6.(b) Name of husband or wife _____
 7. Birth date of deceased (mo., day, yr.) October 15 1878
 8. AGE: Years 69 Months 2 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Oakland, Maryland.
 (Town, county, and state)
 10. Usual occupation Laborer.
 11. Industry or business _____

12. Name Samuel Lloyd Chambers.
 13. Birthplace Oakland, Maryland.
 14. Maiden name Mary Louise Jankey.
 15. Birthplace Near Oakland, Maryland.

16. Informant Mrs. Louise Ferragatti.
 Address New York, N. Y.

17. Burial Date thereof Dec. 30th/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Oakland, Cemetery.
 Location Oakland, Maryland.

18. Funeral director Emory D. Bolden.
 Address Oakland, Md. W.H.

19. 12/30/47 19 47 Julius P. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947 at 3:00 P. M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Spurred after death 19____
 and that I last saw him _____ alive on _____ 19____
 Immediate cause of death _____

Coronary Occlusion
 DURATION _____
 Due to _____
 Due to _____
 Other conditions Malnutrition
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results None
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Ed. Bannister Depty. med
Oakland, Md. examiner
 Address _____ Date signed 2/29/47

RECEIVED

JAN 7 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett
 City or town Rural - Avilton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Rural - Avilton, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Louvina B. Crowe

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife xx Steward Crowe

7. Birth date of deceased (mo., day, yr.) March 22, 1878 6. (c) If alive, give age _____ years

8. AGE: Years 69 Months 8 Days 3 It less than one day _____ hrs. _____ min.

9. Birthplace New Germany - Garrett - Maryland
 (Town, county, and state)

10. Usual occupation Housewife11. Industry or business None12. Name Isreal Duckworth13. Birthplace New Germany, Md.14. Maiden name Mary Wiland15. Birthplace New Germany, Md.16. Informant Mrs. Julius Wilhelm (daughter)Address Star Route, Frostburg, Md.17. Burial xxx Date thereof Dec. 3, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory xxx MethodistLocation New Germany, Md.18. Funeral director Wm. WinterhageAddress Grantsville, Maryland19. Dec 3 19 47 E. H. Broadwater

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 19 47 at 1:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 19 47 to Dec 1 19 47and that I last saw him alive on Nov 29 19 47Immediate cause of death to brain Myocarditis

DURATION

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. R. Davis M.D.

M. D. or other _____

Address Grantsville Date signed Dec 1

RECEIVED

DEC 4 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. *130* *112666*

1. PLACE OF DEATH:

County *Garett*
 City or town *Mt. Lake Park*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *3 1/2 months*
 Hospital, institution, or street address where death occurred:
Kiser Nursing Home
 How long in hospital or institution? *2 1/2 Months*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Allegany*
 City or town *R. D. No 1 Frostburg, Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Lucinda Delbrook

3. (b) Social Security Number

None

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Single*

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) *Oct. 3rd., 1868* 6.(c) If alive, give age _____ years

8. AGE: Years *79* Months *2* Days *27* If less than one day _____ hrs. _____ min.

9. Birthplace *Wellersburg, Pa.*
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name *Unknown*
 13. Birthplace *"*

MOTHER 14. Maiden name *Unknown*
 15. Birthplace *"*

16. Informant *Mr. John Schurg*
 Address *R. D. No 1 Frostburg, Md.*

17. Burial *Burial* Date thereof *1-1-1948*
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory *Porters Cemetery*
Frostburg, Md.
 Location

18. Funeral director *Jacob Hafer*
 Address *Frostburg, Md.*

19. *Jan 1* 19 *48* *Julia A Rowan*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *December 28, 1947* at *9* *38* *A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *October 10th* *1947* to *December 27th* *1947*
 and that I last saw her alive on *December 25th* *1947*

Immediate cause of death *Acute hepatitis* DURATION *1 month*
Was badly Deformed Mentally all of *life*

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

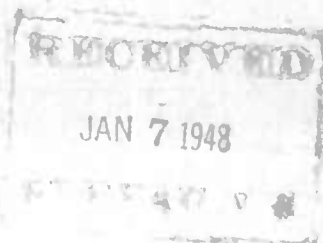
Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Julia A Rowan* M. D. or other _____

Address *Oakland, Maryland* Date signed *12-27-*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11267

Reg. Dist. No. 161

1. PLACE OF DEATH:

County Garnett
 City or town Sangerman
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Garnett
 City or town Sangerman
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clarissa Jane Dewitt

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 21 - 1867

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80212

hrs.

min.

6. Birthplace

Wm

(Town, county, and state)

10. Usual occupation

House Wife

11. Industry or business

FATHER

12. Name

John Rodheaven

13. Birthplace

Wm

MOTHER

14. Maiden name

Friedrich

15. Birthplace

Wm

16. Informant

Mrs

Address

Sangerman Md

17.

(Burial, cremation, or removal). Which?

Date thereof

Dec-15-1947
(month) (day) (year)

Cemetery or crematory

Oak Grove

Location

Near Sangerman

18. Funeral director

M. H. Johnson

Address

Friendsville Md

19.

Dec 15
(Date rec'd by registrar)

19.

47 Kathryn Fike
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Dec 13

19.

47 at 6:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept 18 1947 to Dec 13 1947
 and that I last saw her alive on Dec 11 1947

Immediate cause of death

Cancer of Sinus and Throat

DURATION

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. J. Glover M.D.

M. D. or other

Address

Friendsville Md

Date signed

12-15-47

CERTIFICATE OF DEATH

STATE OF MARYLAND

STATE OF MARYLAND

MEDICAL CERTIFICATE

RECEIVED
DEC 24 1947
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11268
166

1. PLACE OF DEATH:

County Garrett
City or town Swanton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 71 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Swanton
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)
2.(a) If veteran, name war -----

3. (a) FULL NAME

Laura Mosser Friend

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Milton Friend
7. Birth date of deceased (mo., day, yr.) July 24, 1876 8. (c) If alive, give age ----- years
8. AGE: Years 71 Months 5 Days 2 It less than one day ----- hrs. ----- min.

9. Birthplace Garrett Co., Md.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home
12. Name Daniel Mosser
13. Birthplace Garrett Co., Md.
14. Maiden name Annie Barnhouse
15. Birthplace Garrett Co., Md.

16. Informant T. H. Mosser
Address Mt. Lake Park, Md.
Burial Dec. 29, 1947
17. (Burial, cremation, or removal, which?) Date thereof (month) (day) (year)
Cemetery or crematory Deer Park Cemetery
Location Deer Park, Md.
18. Funeral director Herbert C. Leighton
Address Oakland, Md.
19. 12/29/47 Julius Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1947 9:50P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1947 to Dec 25, 1947
and that I last saw him alive on Dec 25, 1947

Immediate cause of death Congestive heart failure
DURATION 3 mo

Due to Hyperlipemic cardio-vascular disease
DURATION 6 yrs

Due to -----
Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----
Date of op. -----

Autopsy results -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of -----
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) -----
Means of injury ----- Injured at work? -----

23. SIGNATURE James W. Leighton Jr MD
M. D. or other
Address President W. Va Date signed 12-29-47

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD INVESTIGATION

REPORT OF SPECIAL AGENT IN CHARGE

TO DIRECTOR, FBI

FROM SAC, [illegible]

SUBJECT: [illegible]

REFERENCE: [illegible]

DATE: [illegible]

BY: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

RECEIVED

JAN 7 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11269

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett
 City or town Rural Oakland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 months
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Penna. County Lackawanna
 City or town Scranton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1255 Providence Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war ----- ✓

3. (a) FULL NAME

Russell J. Garrison

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Louise E. Garrison
 6.(c) If alive, give age 50 years
 7. Birth date of deceased (mo., day, yr.) October 28, 1895
 8. AGE: Years 52 Months 1 Days 17 If less than one day
 ----- hrs. ----- min.

9. Birthplace Penna.
 (Town, county, and state)
 10. Usual occupation Garage Owner
 11. Industry or business Automobiles
 12. Name William J. Garrison
 13. Birthplace Penna.
 14. Maiden name Mary A. Zigenfus
 15. Birthplace Penna.

16. Informant Mrs. R. J. Garrison
 Address 1255 Providence Rd.; Scranton, Pa.

17. Burial Date thereof Dec. 18, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Abington Hills Cemetery
 Location Scranton, Penna.

18. Funeral director Herbert C. Leighton
 Address Oakland, Maryland.

19. 12/18/47 19 47 Julius G. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 19 47 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-15 19 47 to 15 Dec 19 47
 and that I last saw him alive on 12 Dec 19 47

Immediate cause of death Coronary Heart Disease DURATION 1 year

Due to -----

Due to -----

Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----

----- Date of op. -----

Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE A.E. Maurice Row M. D. or other

Address Oakland, Md. Date signed 15-Dec-47

RECEIVED

DEC 19 1947

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11270
166

1. PLACE OF DEATH:

County Garrett
City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Months
Hospital, institution, or street address where death occurred:

How long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)

2. (a) If veteran, name war -----

3. (a) FULL NAME

Mary Ellen Garvey

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife John M. Garvey
6. (c) If alive, give age ----- years
7. Birth date of deceased (mo., day, yr.) September 25, 1866
8. AGE: Years 81 Months 2 Days 11 If less than one day ----- hrs. ----- min.

9. Birthplace Grafton, W. Va.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Own Home
12. Name John Charles Duffy
13. Birthplace Ireland
14. Maiden name Julia Rooney
15. Birthplace Boston, Mass.

16. Informant Margaret Duffy
Address Oakland, Md.

17. Burial Date thereof Dec. 9, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Calvary Cemetery
Location Grafton, W. Va.

18. Funeral director Herbert C. Leighton
Address Oakland, Md.

19. 12/9/47 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1947 3:15A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 to Dec 6 1947
and that I last saw him alive on Dec 5 1947

Immediate cause of death Pulmonary Embolism
Due to -----
Due to -----
Other conditions -----
(Include pregnancy within 3 months of death)

Major findings of operations -----
Date of op. -----

Autopsy results -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of -----
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ----- Injured at work?

23. SIGNATURE E. J. Bannister M.D.
Address Oakland Md Date signed 12/9/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 10 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11271

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garett
 City or town Near Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garett
 City or town R.D. I Grantsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Rebecca Helen Johnson

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

FW

6. (b) Name of husband or wife

October 29-1947

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:	Years	Months	Days	If less than one day
	<u>*</u>	<u>I</u>	<u>20</u>	hrs. min.

9. Birthplace R.D. I. Grantsville Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Jonas H. Johnson13. Birthplace Grantsville Md14. Maiden name Anna L. Fitzpatrick15. Birthplace National Md16. Informant Mary JohnsonAddress Grantsville Md17. Burial Date thereof 12-20-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GrantsvilleLocation Grantsville Md18. Funeral director Wm. SmithAddress Grantsville Md19. Dec 19 1947 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1947 at 4:30a M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

19... 19...

and that I last saw him alive on 19...

Immediate cause of death

Lobar pneumonia

DURATION

3 days

Due to...

Due to...

Other conditions

Found dead in bed

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. R. Davis M.D.

M. D. or other

Address Grantsville Md Date signed Dec 19

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 22 1947

BUREAU

ARTISTIAN LETTER

CONTENT

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11272 172

1. PLACE OF DEATH:

County Garrett
 City or town Rural- Kitzmiller
 (If outside city or town limits, write RURAL and give nearest town)
Imo. Ida.
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
Peerless Hill
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
Rural- Kitzmiller
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Peerless Hill
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Orville Preston King

3. (b) Social Security Number

232-07-7626

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 8. AGE: Years 39 Months 21 Days 29 If less than one day
 12. Name John A King
 13. Birthplace Greenbrier Co., W.Va.
 (Town, county, and state)
 10. Usual occupation Miner
 11. Industry or business Coal Mines
 12. Name Greenbrier Co., W.Va.
 13. Birthplace Nora Ellen Henricks
 14. Maiden name Greenbrier Co., W.Va.
 15. Birthplace Mrs. Hazel Davy
 16. Informant Kitzmiller, Md.
 Address

7. Birth date of deceased (mo., day, yr.) NOVEMBER 7 September 3, 1908 6.(c) If alive, give age years
 8. AGE: Years 39 Months 21 Days 29 If less than one day
 12. Name John A King
 13. Birthplace Greenbrier Co., W.Va.
 14. Maiden name Greenbrier Co., W.Va.
 15. Birthplace Mrs. Hazel Davy
 16. Informant Kitzmiller, Md.
 Address
 17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec. 27, 1947
 (month) (day) (year)
 Cemetery or crematory I.O.O.F. Cemetery
Elk Garden, W. Va.
 Location Otha F. Sharpless
 18. Funeral director Blaine, W.Va.
 Address
 19. 12/24 1947 unburied
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH December 23 1947 11:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1947 to Dec. 23 1947
 and that I last saw him alive on Dec. 23 1947

Immediate cause of death
Acute myocardial
Cardio-Vascular
Renal Disease with
marked edema
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Ralph C. Lambell M.D.
 M. D. or other
 Address Kitzmiller, Md. Date signed Dec. 23-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11273 167

1. PLACE OF DEATH:

County Garrett
 City or town Gormanias, W.Va. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Gormanias, W.Va. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

James Riley Lipscomb

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Verlinda Lipscomb
 6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Nov. 9 1875

8. AGE: Years 72 Months 1 Days 7 If less than one day
hrs.min.

9. Birthplace Fairview, W.Va.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Moses Lipscomb
 13. Birthplace ?

MOTHER 14. Maiden name Mary Montgomery
 15. Birthplace ?

16. Informant Mrs. Edna Perkins
 Address Gormanias, W.Va.

17. Burial Date thereof Dec. 18 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cemetery
Fairview, Md.
 Location

18. Funeral director Wagon & Spiggle
 Address Davis, W.Va.

19. 12/22 1947 Elmer C. Sheffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to December 1947
 and that I last saw him alive in November 1947

Immediate cause of death Acute dilation of heart as ventricular fibrillation as result of effort, sudden death
 Due to hypertensive heart disease with auricular fibrillation 5 yrs.
 Due to Chronic Nephritis 10 yrs.

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Harold C. Miller MD
Egdon, W.Va. M. D. or other
 Address Date signed 12/16/47

RECEIVED

DEC 26 1947

BUREAU 9 *

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. J. H. Walbert, Jr.
830 11274
Reg. Dist. No. 163

1. PLACE OF DEATH:

County Garrett
City or town Barton - rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years
Hospital, institution, or street address where death occurred:
2 1/2 miles West of Barton
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Barton - rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

JOHN JAMES MACGRUDER

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Emma Caplan
Macgruder 6.(c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) April 24, 1866
8. AGE: Years 81 Months 7 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Barton, Allegany, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Own Farm

12. Name James Macgruder
13. Birthplace Unknown

14. Maiden name Jane Baranard
15. Birthplace Maryland

16. Informant Dr. John Macgruder
Address Barton, rural, Maryland

17. Burial Date thereof Dec 21, 1947
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Laurel Hill Cemetery
Maccow, Maryland
Location Ellsworth S. Boal

18. Funeral director Westernport, Maryland
Address 12-20-47

19. 12-20-47 Dorsey Pattison
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1947 at 1042 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1947 to Oct 15 1947 and that I last saw him alive on Oct 15 1947
Immediate cause of death Cerebral Accident

DURATION 6 hrs
Due to Cerebral arteriosclerosis 4 years

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

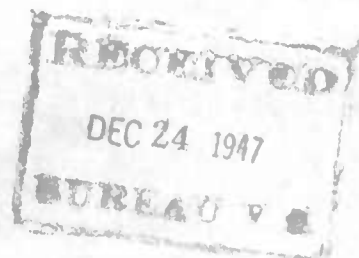
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE James Walbert, Jr. M.D.
M. D. or other _____
Address Piedmont W. Va. Date signed 12-20-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11275
162

1. PLACE OF DEATH:

County Garrett
 City or town Accident
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Garrett
 City or town Accident
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Catharine A. McGettigon

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife James Edward McGettigon
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 25, 1868
 8. AGE: Years 79 Months 7 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Accident-Garrett-Maryland
 (Town, county, and state)

10. Usual occupation Ret. Housewife

11. Industry or business

FATHER 12. Name Henry Feik
 13. Birthplace Germany

MOTHER 14. Maiden name Minerva Cup Feik
 15. Birthplace Virginia

16. Informant Mrs Delon Resh
 Address Accident, Md.

17. Burial Date thereof Dec. 31, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or place of interment English Lutheran
 Location Accident, Maryland

18. Funeral director Wm. McIntosh
 Address Grantsville, Md.

19. Dec 31 19 47 Ethel Broadwater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 19 47 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16 19 47 to Dec 28 19 47
 and that I last saw her alive on Dec. 3 19 47

Immediate cause of death Congestive Heart Failure
Arteriosclerosis.

Due to Arteriosclerosis.
 Due to Arteriosclerosis.
 Other conditions Gall Bladder Disease

(Include pregnancy within 3 months of death)

Major findings of operations. Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE H. J. Gray, M.D.
 Address Friendsville, Md. M. D. or other
 Date signed 12-30-47

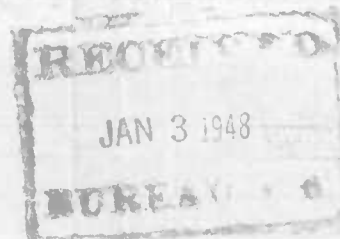
MARGIN RESERVED FOR BINDING

I

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ARTESIAN LEADER



Reg. Diat. No.

VS A15

19. _____ 1947 _____
(Date rec'd by registrar) _____ Registrar

Address..... Date signed 2/15/47

RECEIVED
JAN 6 1948
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 11277 166

1. PLACE OF DEATH:

County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 years
 Hospital, institution, or street address where death occurred:
Kiser Nursing Home
 How long in hospital or institution? 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland. County Garrett
 City or town Mt. Lake Park
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Kiser Nursing Home
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Nellie Jane Riggs

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife William Riggs
 7. Birth date of deceased (mo., day, yr.) April 5, 1872 6.(c) If alive, give age ----- years
 8. AGE: Years 75 Months 8 Days ----- If less than one day ----- hrs. ----- min.

9. Birthplace Chicago, Ill.
 (Town, county, and state)
 10. Usual occupation House Wife
 11. Industry or business Own Home
 12. Name James Evans
 13. Birthplace Unknown
 14. Maiden name Sarah Crowe
 15. Birthplace Unknown

16. Informant Mrs. Nettie Lucas
 Address Kitzmilller, Md.
 Burial 12/7/47
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)
Nethkin Hill Cemetery
 Cemetery or crematory Elk Garden, W. Va.
 Location Herbert C. Leighton
 18. Funeral director Oakland, Md.
 Address 12/7/1947
 19. Julius A. Rowan
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1947 at 8:00A.M.

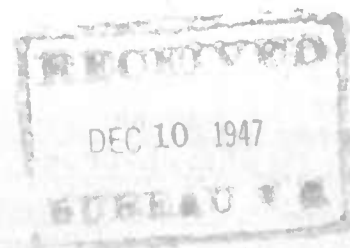
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7th 1945 to December 5th 1947
 and that I last saw her alive on 12-4-47
 Immediate cause of death Heart Failure 3 duration

Due to High blood pressure Nephritis
Rheumatism and heart
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Julius A. Rowan M. D. or other
 Address Oakland, Maryland Date signed 12-7-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11278

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garett
 City or town R.D. I Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Garett
 City or town R.D. I Grantsville Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Charles Schaefer

3. (b) Social Security Number

215-05-7174

4. Sex <u>M</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
6. (b) Name of husband or wife <u>---</u>		
7. Birth date of deceased (mo., day, yr.) <u>January 13-1904</u>		
8. AGE: Years <u>43</u>	Months <u>II</u>	Days <u>-</u>
If less than one day hrs. min.		

9. Birthplace R.D. I Grantsville Md
 (Town, county, and state)

10. Usual occupation Coal Minor

11. Industry or business

FATHER 12. Name Henry Schaefer
 13. Birthplace Germany

MOTHER 14. Maiden name Christena Leinsetter
 15. Birthplace Lonaconing Md

16. Informant James Schaefer

Address R.D. I Grantsville Md

17. Burial Date thereof 12-16-1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grantsville

Location Grantsville Md

18. Funeral director Wm Winterberg

Address Grantsville Md

19. Dec 15- 47 Eduard Braduater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 19 47 at 2:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 46 to Dec 13 19 47
 and that I last saw him alive on Dec 12 19 47

Immediate cause of death Perforated Duodenal Ulcer DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Davis M.D. M. D. or other

Address Grantsville Md Date signed Dec 14

RECEIVED

DEC 19 1947

BUKAY 55

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 172

1. PLACE OF DEATH:
County Garrett
City or town Vindex
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Vindex
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME Perry James Stewart

3. (b) Social Security Number None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Sarah Ellen (Shaffer) Stewart

7. Birth date of deceased (mo., day, yr.) February 22, 1867 6.(c) If alive, give age _____ years

8. AGE: Years 80 Months 10 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Terra Alta, W.Va.
(Town, county, and state)

10. Usual occupation Retired miner
Coal Miner

11. Industry or business David H. Stewart

12. Name Virginia

13. Birthplace Eryann Little

14. Maiden name Virginia

15. Birthplace

16. Informant Mrs. Mary Sharpless
Address Kitzmiller, Md.

Burial Dec. 26, 1947

17. (Burial, cremation, or removal, Which?) Date thereof _____ (month) (day) (year)

Cemetery or crematory Nethken Hill Cemetery

Elk Garden, W.Va.

18. Funeral director Otha F. Sharpless

Address Blaine, W.Va.

19. 12/34/47 Registrar W. B. B. B.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

Dec. 23 47 3:10A

20. DATE OF DEATH _____ 19. _____ at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 19. 47 to Dec. 23 19. 47
and that I last saw him alive on Dec. 23 19. 47

Immediate cause of death _____ DURATION _____

Acute Myocarditis

Due to Cerebral Hemorrhage with

Due to left ventricular hypertrophy

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Ralph Calandella M.D. M. D. or other _____

Address Kitzmiller, Md. Date signed Dec. 23-47

RECEIVED
JAN 30 1948
DELAU 9 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH:

County.....Harz
 City or town.....Friendsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....5 days
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex.....M. 5. Color or race.....W 6. (a) Single, married, widowed, or divorced.....Infant

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....Dec 16 - 1947 6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days.....5 If less than one day..... hrs. min.

9. Birthplace.....Maryland
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....George Thomas13. Birthplace.....Md14. Maiden name.....Lanigan15. Birthplace.....Md16. Informant.....George ThomasAddress.....Friendsville Md17. (Burial, cremation or removal, which)..... Date thereof.....12-22-47
(month) (day) (year)Cemetery or crematory.....Asher BladeLocation.....Near Friendsville Md18. Funeral director.....J. H. LaniganAddress.....Friendsville Md

19. Dec 22 1947 Kathryn Fikes. Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State.....Md County.....Emm
 City or town.....Friendsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Dec 21 1947 at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 16 1947 to Dec 21 1947and that I last saw him alive on Dec 15 1947Immediate cause of death.....Congenital Heart Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....none

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....J. H. Lanigan M.D.Address.....Friendsville MdDate signed.....12-21-47

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

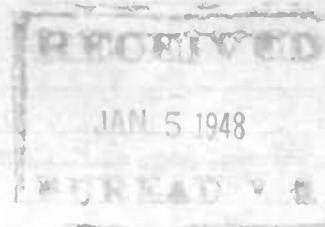
EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11281

Reg. Dist. No. 161

1. PLACE OF DEATH

County Garrett
 City or town (RURAL) Friendsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Approx. 27 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT
 City or town RURAL - FRIENDSVILLE MD.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

MARY S. TURNEY

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race White 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife WILLIAM M. TURNEY
 6.(c) If alive, give age 60 years
 7. Birth date of deceased (mo., day, yr.) JUNE 18 1875
 8. AGE: Years 72 Months 6 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace MENALLEN TWP. PENNA.
 (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business HOUSEKEEPING

12. Name ROBERT WILSON

13. Birthplace PENNA.

14. Maiden name HANNA GRIMES

15. Birthplace PENNA.

16. Informant William M. Turney

Address Friendsville (R.D.) Md.

17. Burial Date thereof JAN. 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Blooming Rose Cemetery

Location FRIENDSVILLE (R.D.) MD.

18. Funeral director H. P. Dehaver

Address Markleysburg - Penna.

19. Dec 31, 1947 Kathryn Fite
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1947 at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1946 to Dec 27, 1947 and that I last saw him alive on Dec 27, 1947

Immediate cause of death Chronic myocarditis DURATION 5 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Milton Jaffer, MD M. D. or other

Address Friendsville Date signed Dec 31, 1947

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

JAN 5 1948

STATE DEPT. OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

11282

166

1. PLACE OF DEATH:

County Garrett
City or town Crellin, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett
City or town Crellin, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ida Charlotta Adaline Welch.

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married.

6.(b) Name of husband or wife John Welch.

7. Birth date of deceased (mo., day, yr.) June 20th, 1875 6.(c) If alive, give age 73 years

8. AGE: Years 72 Months 5 Days 22 If less than one day hrs. min.

9. Birthplace Garrett County.
(Town, county, and state)

10. Usual occupation House Wife.

11. Industry or business

12. Name John F. Sanders.

13. Birthplace Garrett County.

14. Maiden name Elizabeth Sanders.

15. Birthplace Garrett County.

16. Informant Herman Welch.

Address Crellin, Maryland.

17. Burial Date thereof Dec. 14/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Gartner Cemetery.

Location Near Oakland, Md.

18. Funeral director Emory N. Bolden.

Address Oakland, Md.

19. Dec 14 19 47 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH December 11th 19 47 at 4:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6th 19 47 to December 11 19 47

and that I last saw her alive on December 11th 19 47

Immediate cause of death Pneumonia

Due to Influenza

Due to 1 week

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Emory N. Bolden M. D. or other

Address Oakland, Maryland

Date signed 12/14/47

MARGIN RESERVED FOR BINDING

I

9-45-15X

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Edward C. Soler

RECEIVED

DEC 19 1947

81555

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50

1128366

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Garrett
City or town Stanton, M.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Randolph
City or town Beverly
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Mary Elizabeth Welch

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Sept 13, 1860 8. (c) If alive, give age _____ years

8. AGE: Years 87 Months 2 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Preston County, W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Lewis Sovernio 13. Birthplace Preston Co., W. Va.

14. Maiden name Sophia Gibson 15. Birthplace Preston Co., W. Va.

16. Informant W. C. Wilson
Address McMicken, W. Va.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Dec 10, 1947
(month) (day) (year)

Cemetery or crematory Sugar Valley
Location Bruceton, W. Va.

18. Funeral director A. H. Knotts
Address 213 Lincoln St. Grafton, W. Va.

19. 2/10/47 19 47 Julia A. Rowan
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 19 47 at 11:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 October 19 47 to 7 Dec 19 47
and that I last saw him alive on 22 November 19 47

Immediate cause of death Carcinoma - Right Breast DURATION 4 yrs.

Due to Cholelithiasis - acute 2 weeks

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. E. Mauer M.D.
M. D. or other _____

Address Salland, Md. Date signed Dec 47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MEDICAL CERTIFICATE

RECEIVED
DEC 19 1947
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11284

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Mt. Lake Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yearsHospital, institution, or street address where death occurred: Loch Lynn HeightsHow long in hospital or institution? -----

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland. County GarrettCity or town Mt. Lake Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Loch Lynn Heights

(If rural, give LOCATION)

2.(a) If veteran, name war -----

3. (a) FULL NAME

Floyd N. White

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife -----7. Birth date of deceased (mo., day, yr.) January 5, 18768. (c) If alive, give age ----- years8. AGE: Years 71 Months 11 Days 18 If less than one day ----- hrs. ----- min.9. Birthplace Preston Co., W. Va.

(Town, county, and state)

10. Usual occupation Taxie Driver11. Industry or business Self Employed12. Name Jonathin M. White13. Birthplace Garrett Co., Md.14. Maiden name Elizabeth ann Lower15. Birthplace Garrett Co., Md.16. Informant Mrs. Florence HarrisAddress Mt. Lake Park, Md.17. Burial Dec. 24, 1947

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory White CemeteryLocation 5 Mt. So. Oakland, Md.18. Funeral director Herbert C. LeightonAddress Oakland, Md.19. 12/24/47 Registrar Julia A. Rowan

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1947 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1947 to Dec 22 1947and that I last saw him alive on Dec 21 1947Immediate cause of death Ischemic Obstruction

DURATION

Due to -----Due to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE E. J. Bumpkin M.D.Address Oakland Md Date signed 12/23/47

MARGIN RESERVED FOR BINDING

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Prostate's

RECEIVED

JAN 7 1948

ST. PAUL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11285

Reg. Dist. No. 162

1. PLACE OF DEATH:

County Garrett
 City or town Grantsville, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life time
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Garrett
 City or town Grantsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

William Jackson Wright

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Almira (Ringer) Wright
 6. (c) If alive, give age 80 years
 7. Birth date of deceased (mo., day, yr.) Oct. 14, 1862
 8. AGE: Years 85 Months 2 Days 2 If less than one day
 hrs. min.

9. Birthplace Grantsville (Garrett) Maryland
(Town, county, and state)10. Usual occupation Retired Farmer

11. Industry or business

12. Name Walter Wright
 13. Birthplace Not known
 14. Maiden name Elein Ryland
 15. Birthplace Not known

16. Informant Mrs John Hetrick (daughter)
 Address Grantsville, Md.

17. Burial Date thereof Dec. 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematorium Grantsville
 Location Grantsville, Md.

18. Funeral director Wm Winterberg
 Address Grantsville, Md.

19. Dec 18 1947 Ethel Broadwater
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1947 at 11:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Dec 16 1947
 and that I last saw him alive on Dec 15 1947

Immediate cause of death Cerebral hemorrhage
 DURATION

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. R. Davis M.D. M. D. or otherAddress Grantsville Md Date signed Dec 18

RECEIVED

DEC 22 1947

BUREAU